Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

2015 MAR 27 P 12:33

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	11-94.1 Initial Comments A state relicensure survey was conducted at the facility from 2/9 - 2/13/15. At the time of the entrance, the resident census was 117.	4 000		
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Statute is not met as evidenced by: Based on obervations, resident andstaff interviews, and policy review, the facility's Quality Assessment and Assurance committee failed to identify quality deficiencies and failed to develop and implement appropriate plans of action to correct quality deficiencies identified in the facilities Occurence Investigation Form. The facilty failed to effectively and efficiently attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Administrator and Director of Nursing failed to communicate and recommend trending, analysis to determine systemic improvements to the Quality Assessment and Quality Assurance committee. The survey team determined the facility was providing substandard quality of care and actual harm. An extended survey was initiated. Findings include: 1) Part 2 of the Quality Assessment and Assurance (QAA) review was conducted on 02/13/2015 at 9:35 AM in attendance were the	4 088	**4 088- GOVERNING BODY AND MANAGEMENT** **#1 – Individual** This deficient practice is administrative and therefore no individualized corrective action was instituted. **#2 – Other Residents** All residents in facility are at risk for this finding as listed on the statement of deficiencies. **#3 – Systemic Changes** Revised and improved Quality Assurance(QA) Incident and Investigation reports are being implemented by facility after training is completed with licensed nursing staff. These reports will be completed by Licensed Nursing staff immediately upon any required incident, including falls and elopements from property of facility. Incidents will be discussed in facility's daily (generally 5 days/week) Interdisciplinary Team(IDT) meeting to ensure investigations are in progress as needed, completion thereof, and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 088	Continued From page 1 Administrator (ADM), Quality Assurance Auditor (QA) and the Director of Nursing (DON). The ADM and QA stated the Quality Assurance committee has a falls report in place to document fall occurrences and causes, diagnosis, and patterns. The facility uses an Occurrence Investigation Form to identify concerns. Quarterly reports are reviewed to see what has happened on the floors, from there the committee start the assessment process. The meetings are not resident specific - a single incident may not be a red flag. A review of the facility's policy titled, " Occurrence Event Report for Residents & Visitors", revised 4/15/08, indicated reportable events included: a. Witnessed and unwitnessed falls/slips; k. Elopements: The policy noted, " II. Documentation: e. Events alleged as possible abuse/neglect will be subject to further investigation and reporting, as appropriate, to the Department of Health, Office of Healthcare Assurance, by the Administrator within the required reportable time as regulated; f. Event reports will be analyzed and monitored for trending and further action/recommendations as presented during the quarterly Quality Improvement Committee meetings. R #1 had a history of elopements on 9/7/13, 7/27/14, and 1/9/15. A review of the facility's "Occurrence Investigation Form " indicated that the QAA failed to identify, analyze, and update interventions for the risks/hazards associated with the elopements. R#1 had a history of falls on 10/19/13, 2/31/14, 4/20/14 and 6/19/14. The fall on 4/20/14 resulted in injury . A review of the facility's "Occurrence Investigation Form" indicated the QAA failed to identify, analyze, and update interventions for fall	4 088	analyze, identify and update any interventions that may reduce risks and hazards to residents. A trending report will be updated on these same days, and the report will be reviewed weekly by the IDT. This data will then be compiled and reported to the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly basis for further review and recommendations. Therefore, all incident reports are being discussed and evaluated daily. REPORTING Administrator recognizes and accepts sole responsibility of ensuring any and all reportable incidents will be reported to State Agency within required times. Administrator, DON and/or Nursing Supervisor will meet each workday to collaborate on any events needing immediate attention and/or to be reported to QAPI committee. **#4 – Monitor** To ensure Quality Assurance is maintained, a copy of the facilities Incident Log (Trending Report) will be randomly audited by Quality Assurance Auditor on a monthly basis to ensure compliance of investigations as well as reporting requirements to SA.	3/30/15 3/23/15 and Ongoing 3/30/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 088	Continued From page 2 risk. R#174 fell on 1/16/15 and 2/2/15. On 2/12/14 at 8:27AM the DON was asked whether the facility did a root cause analysis and implemented approriate inteventions based on their analysis. The DON replied "probably not". 2) On 02/13/2015 at 9:35 AM during an interview to discuss Quality Assessment and Quality Assurance (QAA) with the Administrator, Quality Assurance Auditor (QA) and the Director of Nursing (DON), the Administrator stated the Quality Assurance committee determines that an action plan is needed brought up by feedback from staff; observations; other facility concerns. For care plan updates the staff uses a blue marker and hand writes a discontinued date. Because the care plans are hand written they can get difficult to read. They are templating the care plans trying to make them easier to read and individualized. Staff are providing care according to the directives of these action plans. Implementation of plans are through seeing a trend (such as falls) and constantly adjusting plans as part of the whole process. When informed of the obervation that the residents care plans for falls (R#1 and R#174), elopement (R#1) and vision (R#1 and R #162) were not being followed by staff, or updated to address their current needs. That there was inadequate assessment of the root causes for each of these incidents event, the QA stated this may be something the QAA could study. 3) There was general lack of knowledge on contact time and use of santizers by staff workers throughout the faciltiy. On 02/11/2015 at 3:07 PM the Administrator (ADM), Director of Nursing (DON), and Infection Control Coordinator (LCC)	4 088		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 088	Continued From page 3 who was present by phone conference met. The LCC was informed that Morning Mist is used at the facility and when random staff was queried there were many different responses on contact time, when to use the different sanitizers, and the ESC was not following the recommended Morning Mist policy on contact time. The LCC stated, "no, they do not use Morning Mist, the facility uses the Purple top sani wipes". The ADM and DON informed the LCC that the facility does use Morning Mist. The LCC stated "this is a weak point in the program (Infection Control) I am disappointed." 4) R#1 Occurrence Event Report for elopement occurring 1/9/15, 7/27/14 and 9/7/13 was completed by the charge nurse; reviewed and signed by the Adminitrator and Director of Nursing; and not marked for assessment of trends and determination of systemic improvements. The Administrator and/or DON did not make a recommendation to the Quality Assessment and Qualtiy Assurance committee for review and analysis of the repeated events. R#1 Occurence Event Report for a fall occurring 6/9/14 that resulted in injury was signed by the former facilities Administrator and current DON and not marked for assessment of trends and determination of systemic improvements. In the facilities policy on Occurrence Event Report for Residents & Visitors revised 4/15/08 f. Event reports will be analyzed and monitored for trending and further action/recommendations as presented during the quarter Quality Improvement. 5)R#1 elopements and fall are reportable events to the State Agency. In the facility's policy on Occurrence Event Report for Residents & Visitors	4 088		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 088	Continued From page 4 revised 4/15/08 for unwitnessed falls and elopements the facility's policy titled, " Occurrence Event Report for Residents & Visitors", revised 4/15/08, unwitnessed falls and elopements will be subject to further investigation and reporting, as appropriate, to the Department of Health, Office of Healthcare Assurance, by the Administrator within the required reportable time as regulated. For the elopement and falls the facility failed to send the required report to the State Agency. The DON stated "I assumed the Administrator would submit a report to the State agency and he thought I would do the report." Both the Administror and Director of Nursing failed to check with each other to see if the report of the events were sent to the state agency. An investigation at the Office of Health Care Assurance for events reports sent in by the facility verified that there was no report sent into the state agency for elopements and fall for R#1. 6) On 2/12/15 at approximately 2:15pm the DON stated in an interview that she spoke to the Administrator (now retired) of possible abuse/neglect by the CNA caring for R#1. Both the DON and Administrator failed to follow the facility's policy to ensure the prevention, and safety of all residents from incidences of abuse, neglect or misappropriation of property. In the facility's policy "Investigation of Alleged Violations Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, Unusual Occurences and Misappropriation of Resident Property", it states all alleged violations involving neglect, abuse, injuries of uknown source and misappropriation of resident property, are reported immediately to the Administrator of the facility. Such violations shall also be reported to State agencies in accordance with State law.	4 088		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 088	Continued From page 5 The QAA's failure to identify quality deficiencies and develop and implement plans of action to correct these deficiences, including monoitoring the effect implemented changes and making needed revisions to the action plan affects the overall quality of care to all residents at the facility. The faciltiy Administrator and Director of Nursing hold positions of leadership within the facility their oversight of the occurrence event reports and communication of recommendations to the Quality Assessment and Assurance committee is an important safeguard for the quality of life and quality of care to the residents.	4 088		
4 115	11-94.1-27(4) Resident rights and facility practices Written policies regarding the rights and responsibilities of residents during the resident's stay in the facility shall be established and shall be made available to the resident, resident family, legal guardian, surrogate, sponsoring agency or representative payee, and the public upon request. A facility must protect and promote the rights of each resident, including: (4) The right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility; This Statute is not met as evidenced by: Based on resident interviews, record review, and review of Resident Council meeting minutes, the facility failed to maintain respect and dignity for the residents.	4 115	**4 115 - RESIDENT RIGHTS AND FACILITY PRACTICES** **#1 – Resident** After being informed of the concern, the Social Worker and Activity Coordinator met with Res #129 and Res #174 on March 11, 2015. Both residents were unable to pinpoint specific staff that were rude and spoke a language other than English and did not respond to call light timely. Both residents were informed that the facility is developing specific plans to prevent similar situations from recurring through facility-wide staff education, staff counseling and/or disciplinary action on an ongoing basis with continued monitoring and analyzing.	03/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 6 Findings include: 1) During a Resident, R #129, interview on the morning of 2/10/15, she reported the facility staff spoke loudly at the Nurse's station. The R #129's room was close to the Nurse's station. She stated it was disruptive. The R #129 also stated that some staff was rude to her. She was unable to pinpoint a particular shift or staff person who was rude. She stated, "Some of them (staff) are rude while some are nice. Some staff talk rough to me." She also reported that the staff often spoke in a language other than English. She said she didn't like it when the staff spoke Filipino in front of her. She stated, "That really irritates me when they speak Filipino. I feel disrespected." A review of R #129's medical record revealed she had a BIMS (Brief Interview for Mental Status) assessment on 1/1/15 with a score of 12/15. Her score indicated she was alert and oriented with a fairly intact memory. 2) On 2/10/15 at 12:30 P.M. the resident council representative provided permission for the surveyor to review the minutes of the council meeting. A review of the minutes was done on the afternoon of 2/10/15. The minutes of 3/28/14 noted the council complained that staff were not speaking in English. The minutes of 1/30/15 noted the council mentioned that staff members are not speaking in English, the council voiced that this has not improved and it is constant. 3) On 2/11/15 at 9:28 A.M. an interview was conducted with Resident #174. The resident reported she uses the call light for assistance to use the bathroom and while waiting for staff	4 115	**#2 – Other Residents** All residents are at risk of this potential deficient practice. **#3 – Systemic Changes** Resident council members will be informed at the next resident council meeting that corrective actions are being planned and implemented to ensure that staff do not speak a language other than English (unless requested by resident and appropriate care plan is in place) and ongoing evaluation and monitoring will take place. Staff Education will be done for employees of all departments to review this deficient practice on speaking a language other than English, treating residents with dignity and respect, and answering call lights in a timely manner. Failure to comply with policies and procedures will result in disciplinary action. Director of Social Services and Activity Coordinator developed a resident interview questionnaire on 3-10-2015 focusing on questions directly from the CMS "Resident Interview and Resident Observation Form". All residents that score 12 or higher on the BIMS assessment will be interviewed by 3-30-2015. Results of resident	3/30/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 115	Continued From page 7 members she has had toilet accidents. The resident reported that it is embarrassing to go "shi-shi" (urinate) in her pants. 4) On 02/13/2015 9:35:42 AM during an interview with the Director of Nursing, Quality Assurance Auditor, and Administrator to discuss the quality assurance and assessment (QAA) activities, the Administrator verified they remind staff to speak English while at the facility.	4 115	responses will be forwarded to the employee's respective supervisor for follow up as needed. A monitoring tool will be developed to randomly audit noise level, language spoken and response to call lights by the IDT members. Results of this audit will be discussed weekly in the IDT meetings to ensure needed follow-up by respective supervisor. Audit will be done quarterly for one year and every 6 months the next year.	3/30/15 and Ongoing 3/30/15 and Ongoing
4 130	11-94.1-29(a) Resident abuse, neglect, and misappropriation (a) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Statute is not met as evidenced by: Based on observations, residents and staff interviews, record review, and review of the facility policy and procedures, the facility failed to ensure the safety of their residents so that each resident receives adequate supervision and assistance devices to prevent accidents for 2 of the 3 residents investigated for accidents (R #1 and R#174) in the Stage 2 sample of 38 residents; resulting in an Immediate Jeopardy (IJ) for one resident (R#1). Finding includes: 1)The R #1 was being investigated for a fall he endured in April 2014 which resulted in a left leg	4 130	**#4 - Monitor** The resident interviews and random unit audits will be done quarterly for (1) year then every (6) months thereafter. The results of the resident questionnaire and follow-up will be discussed and analyzed at the quarterly QAPI meetings, as well as updates to resident council and staff . At each Resident council meeting, members will be asked to provide feedback regarding staff speaking English and IDT will ensure that follow-up action is done by respective supervisor to prevent the same deficient practice.	3/23/15 and ongoing 3/30/15 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 8 fracture. During the investigation of the R #1's fall on the afternoon of 2/12/15, a Licensed Nurse #5 (LN#5), reported to the Surveyor that the R #1 was "difficult and occasionally combative". The LN #5 further indicated the R #1 often left the facility without permission. She stated that he liked going to a store next to the facility. The LN #5 stated that the R #1 was sometimes found in the facility's parking lot and was sometimes found off the premises. A review of the resident's medical record found the following diagnoses: Anoxic encephalopathy, Paraplegia, and Seizure disorder. The R #1's latest Resident Assessment Instrument, RAI, with assessment reference date of 11/29/14 found he had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points. The R #1's BIMS score revealed he was alert and oriented to person, place and time. He utilized a wheelchair which he was able to wheel around independently. The LN #5 provided a listing of when the resident eloped in the past. The R #1 resided on the 4th floor of the facility. A review of the incidents revealed the R #1 attempted to leave the facility on 9/7/13 when he was found wheeling himself out of the parking lot on the ground floor to a store next to the facility. Following this incident, the facility generated a care plan on 9/9/13 titled, "I want to go outside on my own." The care plan goal was that R #1 would be accompanied by someone to go outside and he would be reminded he couldn't go on his own over the next 6 months. The care plan interventions included, "Place Wanderguard on wheelchair at all times; Inform [R #1] he can go outdoors with someone accompanying him; Remind [R #1] to let staff know when he wishes to go outside; Offer to take	4 130	**4 130 RESIDENT ABUSE, NEGLECT, AND MISAPPROPRIATION** **#1 – Resident** A 1:1 sitter was assigned 24 hours, for R#1 on 2/12/15. A 1:1 supervision care plan was developed for Res #1 with elopement concerns, on 2/13/2015. On 2/20/15, the facility procured and tested a wander guard band and it was attached to R#1's wheelchair on 2/20/15. 1:1 supervision was discontinued on 2/23/15, and the care plan was adjusted accordingly. The Elopement Care Plan for R#1 was revised on 2/23/2015 to include the wander guard and the intervention to initiate a 1:1 sitter, in the event that a wander guard band is not available. Additional exit door alarms were installed on 2/13/15 on the 4th floor stairway exits, in order to alarm employees when an exit attempt is made at the stairway exits. R#1's ADL sheets, care plan and care card were reviewed on 2/11/15 by Charge Nurse. It was confirmed that these documents indicated a 2 person transfer with mechanical lift. FS re-educated all 4th floor unit staff on the importance of reviewing care plans and ADL sheets on a daily basis on 2/11/15. FS counseled the involved MDS nurse on using documentation available in the	2/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 9 [R #1] outdoors for fresh air/stroll at least 2 times per week ". The care plan was current during the 2/13/15 survey. The R #1 again eloped on 7/27/14 when a Certified Nurses Aide (CNA) was unable to find him on the unit. The Licenced Nurse #2 (LN#2) went down to the parking lot of the facility and found the resident there. The R #1 informed the LN #2, " I want to buy something at the store." The LN #2 accompanied the resident to the store where he bought 2 bottles of iced tea and the LN #2 brought him back to the facility. Another care plan was generated on 7/27/14 titled, "Elopement" which noted the problem, "Resident went down to the parking lot unaccompanied without notifying staff (elopement)". The interventions included, "Wanderguard to be placed on wheelchair to alert staff when resident tries to enter the elevator." The care plan was current during the 2/13/15 survey. The R #1 again eloped on 1/9/15 at 8:00 P.M. Another resident's family member saw the R #1 wheeling himself out of the elevator on the ground floor. The family member reported it to the Licensed Nurse #6 (LN # 6) who was the Charge Nurse. A staff member went down to get R #1 when he said, "I like go to the Korean store." The staff member accompanied R #1 to the store but it was already closed. The R #1 was returned to the facility in stable condition. During observations on the morning of 2/12/15, the R #1 did not have a Wanderguard alarm on his wheelchair. An interview with the Certified Nurse Aide #1 (CNA #1) on the morning of 2/12/15 revealed the R #1 no longer used the Wanderguard. An interview of the Licensed Nurse #2 (LN #2) on the morning of 2/12/15	4 130	record to code accurately. FS#1 re-educated all LN on the fourth floor, on the importance of updating care plans with new interventions, every time a change to the plan of care has been made, or in the event that a hazardous event has occurred, as well as the importance of ensuring that all interventions listed on the care plan are active. FS#1 re-educated all C.N.A's on the importance of checking the care card and the ADL sheets, on a daily basis to ensure that assistive devices are in place, as well as ensuring that the plan of care is followed. Charge nurse created a care plan for R#174 on 2/12/15, to include current psychoactive medications, as well as behaviors to watch for and side effects of the medication (Mirtazapine and Lorazepam). FS#1 updated the behavior monitoring sheets was revised (2/12/15), to include the side effects of the medications lorazepam and mirtazapine, and to include non-pharmacological interventions and parameters before the use of the prn medications. FS #1 counseled all fourth floor staff on 2/23/15, on the importance of non- pharmacological interventions, current psychoactive medications, as well as behaviors to watch for and side effects of the medication (Mirtazapine	2/11/15 2/13/15 2/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 10 revealed the R #1 did not have a Wanderguard alarm. A demonstration of the Wanderguard testing system was conducted by the Environmental Services Coordinator (ESC) on the morning of 2/12/15 at approximately 11:30 A.M. During the demonstration, the ESC asked the nursing staff for a resident who was using the Wanderguard alarm. The nursing staff informed the ESC that none of the residents on the 4th floor used the Wanderguard alarm system. The R #1 resided on the 4th floor. An interview with the Director of Nursing (DON), on the afternoon of 2/12/15 at approximately 2:15 P.M. revealed she attempted to keep the R #1 from eloping but he continued to do so. She stated, "As much as we remind him and encourage him to seek assistance, he continues to do so." The DON referenced the care plan, "Desire to go outside", and stated they maintain a Wanderguard alarm on his wheelchair at all times. The DON reported the Wanderguard was R #1's safety net to prevent him from leaving the facility unaccompanied. The Surveyor asked if R #1 was still utilizing the Wanderguard and she responded, "Yes, didn't you see it?" The Surveyor informed the DON that observations made on 2/9/15, 2/10/15, 2/11/15, and the morning of 2/12/15 revealed the R #1 did not have a Wanderguard in place. The DON stated, "To be honest, the Wanderguard system we have is antiquated. We aren't able to order new devices for the residents. We determine who absolutely needs it then reassign them as needed." The DON further stated, "He may be less of a risk than another resident. It was determined because he goes outside to the store around the corner and then he comes back. We teach him to not do that." She stated, "He had the Wanderguard on then another resident	4 130	and Lorazepam). FS #1 counseled all fourth floor staff on 2/23/15 on the importance of knowing the reason for administering a prescribed medication, as well as possible side effects associated with this medication. Charge Nurse (CN) checked R# 174's bed alarm for proper functioning, and ensured placement of floor mats on both sides of the bed 2/11/15. CN reviewed and updated the Risk for Fall care plan for R# 174 on 2/11/15, to reflect new interventions. Care card was updated to reflect the addition of devices and its proper use for the involved resident. Charge nurse spoke with responsible party, as well as the resident (2/16/15) for approval of the intervention "bring R#174's bed out to the hallway (nurses station), at night, when restless behaviors are noted. Care Plan updated 2/16/15. Care plan was updated on 3/10/15 to include a complete a bladder diary for one week, in order to determine voiding patterns in order create patient specific interventions related to anticipating toileting needs. On 2/13/15, FS reminded all staff that the call alarms are crucial to assessing resident needs and preventing resident injuries. In addition, all staff were reminded that the call light system alerts the nurse's station when a call button has been unplugged, of the expectation to promptly answer call lights and to	2/23/15 3/10/15 2/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 11 comes along with less cognition than him so we would swap it out to that resident." The DON was unsure of the number of Wanderguards the facility had. The DON reported R #1 was safe to go on his own to the store. Inquired whether the facility assessed the resident for safety, the DON replied he was not assessed. Further inquired whether there was the likelihood that R #1 would elope again, the DON replied," Yes." A Surveyor team meeting was conducted on 2/12/15 at approximately 3:00 P.M. to determine the level of harm. The Survey team determined an Immediate Jeopardy (IJ), was in progress. The team leader notified the Hawaii State Survey Agency's supervisor, the Medicare Certification Officer (MCO), who concurred with the IJ. The Survey team attempted to notify the Regional Office(RO), of the IJ but because of the time difference the RO staff had already left the office for the day. The Survey team met with the Administrator and DON on the afternoon of 2/12/15 at approximately 3:45 P.M. to inform them of the IJ. The Administrator and DON stated they would immediately write a Plan Of Correction, POC, for the IJ. The facility provided a written POC for the IJ which was accepted by the Survey team on 2/12/15 at approximately 4:30 P.M. The facility documented that they would provide one to one supervision of R #1 until their alarm system could be updated. The one to one supervision had already been implemented for the resident. The RO Long Term Care (LTC) Supervisor was notified of the IJ on the morning of 2/13/15 at approximately 10:00 A.M. Hawaii Standard Time.	4 130	assess resident needs. **#2 – Other Residents** All residents who are on psychotropic medications and diuretic meds are assessed and care plan updated. Residents name listed in the psychotropic med list sent by the pharmacy will be sent to DON/Supervisor for audits of care plans and complete documentation on all required forms. Residents manifesting wandering behavior will be considered to be at risk for wandering/elopement. Residents with Secion E and V of the MDS 3.0 triggered will be determined as potential wanderer/elopement risk resident. Residents that have an incident report completed or an incident investigated will have specific interventions put into place as well as immediate update to related care plans. All residents determined to be at risk for falls will be placed on the "at risk for fall" protocol. **#3 – Systemic Changes** Develop a C.N.A endorsement form,	2/13/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 12 The RO LTC Supervisor supported the IJ. 2) An interview was conducted with R #1 on the afternoon of 2/9/15 when he stated that a CNA "broke my knee." He stated the CNA pushed him in his wheelchair into his room where he fell out of his wheelchair and broke his left leg. He stated, "It was so sore. It was the most painful thing I ever felt." He reported that the CNA has since resigned from the facility and therefore no longer worked there. He reported it was a male CNA. Investigation of the resident's complaint revealed the facility failed to prevent further injuries, as evidenced by their knowledge of the R #'s high risk for falls without revising interventions to promote his highest practicable potential physical well-being. An observation of R #1 in the afternoon of 2/9/15 found him in a wheelchair, wearing black gloves, a baseball cap with sunglasses on top, and a large knee brace on his left leg. The resident was able to wheel himself around the unit. A review of the facility's incident log on the morning of 2/12/15 found the The R #1 experienced falls on 10/19/13 (no injuries), 3/31/14 (no injuries), 4/20/14, and 6/9/14 (no injuries). The R #1 sustained injuries from the 4/20/14 fall when he was found on the floor lying on his left side partially under the corner of the foot of the bed with his left arm behind him. The physician was notified and ordered x-rays of his left hip and leg. The x-rays revealed the resident had a depressed tibial plateau fracture. He was transferred to the hospital for treatment and later returned to the nursing facility. On 6/9/14 at approximately 7:50 P.M., the R #1 was found on the floor lying on his left side and was holding his left leg up with both hands and his right leg was in	4 130	which will provide specifics about the resident's care needs C.N.A. will complete an endorsement form that will be signed by the outgoing as well as the incoming C.N.A. The form will include information on assistive devices, safety devices, as well as transfer needs . The completed form will be kept in a C.N.A endorsement binder, which will be made available to all nurses completing the MDS. In-service IDT involved in care planning on proper documentation and revision of care plans. -Reeducation for all staff on the specifics of the currently established fall protocol. Residents that have an incident of accident or hazardous situation, will be identified in an Incident/ Investigation form, that will be found in an "Event" binder that will provide step-by-step instructions on what will need to be completed for each specific type of incident. New incident report form to include resident participation to determine new interventions will be developed and implemented on 03/23/2015 after staff education is completed. This form will include a step-by-step guide to investigate an event for a root-cause. The new incident report and incident	3/30/15 3/30/15 3/30/15 3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 13 a bent position on the floor with his head raised. When asked if he hit his head on the floor, he replied, "Not really." A medical record review on the afternoon of 2/11/15 found the facility routinely assessed the resident for his fall risk. The facility conducted their "Fall Risk Assessment (Attachment A)" on: 10/3/13 with a score of 8 (8-18=high risk, initiate Fall Prevention Protocol [Falling Coconut]"; 10/18/13 with a score of 10; 12/19/13 with a score of 10; 4/11/14 with a score of 12; 4/20/14 with a score of 13; 6/11/14 with a score of 13; 9/5/14 with a score of 13; and 12/2/14 with a score of 13. A review of the care plans revealed a care plan dated 3/15/14 (Updated) and titled, "Risk for Fall. (R #1) is at risk for fall related to history of falls and use of psychoactive drugs (Zoloft) and need for assistance with ADL's and impaired balance/gait." Interventions included, "Use the mechanical lift with 2 persons assisting him for transfers." Since his fall on 4/20/14 and 6/9/14, no intervention changes were made to the Falls care plan. The care plan was current during the 2/13/15 survey. An interview of R #1 on the afternoon of 2/11/15 found that when he fell on 4/20/14, the facility was providing 1 person transfer assistance. After the 4/20/14 incident, the facility changed to 2 person assistance during transfers. On the afternoon of 2/11/15, a review of the Resident Assessment Instrument, RAI, with Assessment Reference Date, ARD, of 3/13/14 revealed the R # 1 was able to independently move between locations in his wheelchair with setup assistance; and he was totally dependent with 2-person assistance for transfers. The RAI with ARD of 6/8/14 (after the 4/20/14 fall) indicated the R #1 was totally	4 130	investigation will be maintained in a binder that will be specific to events only. This binder will provide information on every step that will need to be completed for that specific event (i.e. Contact family, update the care plan, update the behavioral monitoring sheet, investigate the resident etc.) **#4 – Monitor** Nursing supervisors will monitor the completion of endorsement forms, as well as acknowledgement signatures by C.N.A., on a daily basis, for 30 days once forms are implemented. The QAA will perform random audits on compliance thereafter. Nursing supervisors will assess for completion of the event report form after the end of every investigation. They will audit for related changes in the care plan, as well as track specific incidences of improperly completed investigation forms. Immediate remediation will be performed with the involved employee. Data collected by the nursing supervisor about incomplete incident investigation reports, will be presented at scheduled QAPI meetings. Using the incident investigation form, the nursing supervisor will ensure that appropriate changes to the care plan have been made. MDS nurses will also	3/30/15 and ongoing 3/30/15 and ongoing 3/30/15 and ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 14 dependent and required one person assistance to move between locations in his wheelchair; and his transfer ability remained the same as the 3/13/14 RAI. The most current RAI with ARD of 11/29/14 indicated the R #1 did not move between locations; and he continued to be totally dependent with 1 person assistance for transfers (no longer 2 person assistance). An interview of the DON on the afternoon of 2/12/15 at approximately 2:15 P.M. revealed the Social Worker, SW, notified her of R #1's fall with the report that he fell out of his wheelchair. The DON stated, "I thought it was 'suspicious'." The DON explained that on 4/20/14, the CNA caring for R #1 wheeled him into his room. The CNA attempted to place the mechanical lift sling under the resident by pushing the R #1 forward in his wheelchair. The CNA realized he forgot the mechanical lift; and left the room to get the lift. The DON stated a staff member heard the resident had fallen. The staff member went in to help the CNA pick him up. She reported that she received varying reports from staff members and the Resident. The DON stated that she spoke with the then Administrator (who was no longer employed at the facility) about her concerns with the CNA. The DON stated her concern was possible abuse/neglect by the CNA based on the information she had collected up to that time. The CNA was off for the next few days when the DON attempted to contact him at home. The DON left several messages and never received a return call. The CNA was scheduled to work on a Saturday, when the DON was off, so she asked another LN to get a statement from the CNA. The statement from the CNA stated, "I left the room. He fell. Effective today, I resign." The DON stated, "It was hard for me to make a	4 130	review care plans with scheduled MDS assessments. LN review care plans during the care conferences. During quality care conference meetings, the need for safety devices are reviewed. All staff will be in-serviced regarding the use of the new incident report. Each incident will be discussed in IDT meeting to ensure investigations are in progress as needed, completion thereof, and to analyze, identify and update any interventions that may reduce risks and hazards to residents. A trending report will be updated on these same days, and the report will be reviewed weekly by the IDT. This data will then be compiled and reported to the QAPI Committee further review and recommendation.	3/30/15 3/30/15 3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 15 decision whether it was abuse. Statements from involved parties revealed the resident's story changed with different staff members." The DON stated that she didn't have concerns in care areas with the CNA. When asked if she had concerns about that CNA, she said she thought he was aloof and behaved like a teenager. The DON then stated that she never personally met the CNA. She stated the CNA worked night shift and somehow she never crossed paths with him. The DON was asked what types of safeguards she put in place to prevent further injury of R #1 since the 4/20/14 fall. She replied, "It was taken care of since the CNA resigned. If he hadn't resigned, he probably would've been terminated. As far as his previous falls, I wasn't here for those." When asked about changes in interventions, she stated they used episodic care plans for fall prevention. She indicated that the Ward Clerk might have thinned the chart. The DON was asked about reporting their policy for reporting significant injuries to the State Agency, SA. She stated they reported major injuries. She further indicated that the previous Administrator (who left 10/14) was responsible for reporting to the SA. She stated, "I wasn't brought into it at all." The R #1's accident on 6/9/14 was avoidable as evidenced by the facility's failure to implement the resident's care plan to use 2 persons for transferring this resident which resulted in injury (depressed tibial plateau fracture). 3) Resident #174 was admitted to the facility on 12/26/14 with hospice services. The staff interview done on 2/9/15 at 1:23 P.M., the staff member reported Resident #174 fell on 2/2/15	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 16 resulting in a fracture of the right wrist. The staff member also reported the resident fell on 1/16/15 with no injury. On 2/10/15 at 12:40 P.M., Resident #174 (R#174) was observed in bed asleep, the bedside table was placed across her body, there was no pad on the floor. At 1:56 P.M. observed a staff member placing a second floor padding atop the pad that was already placed to the resident's left side. On 2/11/15 at 7:49 A.M. observed the resident seated in the dining room with an alarm clipped to her clothing. Observation on 2/12/15 at 8:22 A.M. found the resident feeding herself, using her right hand with the splint applied. On 2/12/15 at 9:52 A.M. observed Resident #174 ambulating with a forward wheel walker and the assistance of one staff member to the activity room. Review of the facility's "Occurrence Event Report" documents on 1/16/15 at 10:10 P.M. Resident #174 was found on the hallway floor stating she fell from bed. The witness notes that he/she was charting at the nursing station and heard "help me" and saw the resident crawling in the hallway, attempting to stand, pushing the plastic isolation cart outside of Room 408. The resident stated she wanted to use the bathroom. The initial finding in the even report documents the personal alarm was attached and the bed alarm was turned on. Review of the "Interdisciplinary Progress Notes" (IPN) documents on 1/16/15 (2215) at 2215 resident was found crawling on the hallway floor asking for help. The nurse also documents the personal alarm attached, bed alarm on, call light within reach and reminded resident to ask for help when needs assistance. Resident #174 had another fall on 2/2/15. Review of the "Occurrence Event Report" notes	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 17 the resident's alarm was heard and before staff member stepped into the room, a loud "bang" sound was heard in the bathroom. The resident was found in "lying position under the sink". The resident was responsive and alert and sustained a bump on the head and skin tear. The initial investigative findings note the personal alarm was attached and the bed alarm turned on. The resident was in Room 413. Record review on the afternoon of 2/10/15 found an admission Minimum Data Set with assessment reference date of 12/30/14 which notes Resident #174 yielded a score of 14 (cognitively intact) on the Brief Interview for Mental Status. Review of Section G. Functional Status, notes the resident requires limited assistance with one person assistance for bed mobility, transfer, walking in room, and toilet use. The resident was also coded to be occasionally incontinent of urine and always continent of bowel. The Care Area Assessment notes the resident has poor safety awareness that puts her at risk for falls. A bed alarm is utilized and a personal alarm is utilized when she is out of bed; however, the resident can remove the personal alarm. A review of the care plan dated 12/26/14, risk for fall related to poor safety awareness, history of falls, cognitive impairment, assistance with activities of daily living and impaired balance/gait was done. The goal is for no fall incident within the next 90 days. Interventions include: assess level of cognition and function q shift and prn; orient resident to staff, roommates, and room; place call light within easy reach; anticipate resident's needs; personal alarm on at all times and attached to clothing; keep environment clutter free and adequate light; monitor often for	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 18 safety; proper transfer technique; monitor for signs/symptoms of pain and administer pain meds prn; use of assistive device in transfers and ambulation; monitor for side effects of drugs, update MD/NP as needed; observe for signs/symptoms of delirium, update MD/NP as needed; and follow consultant pharmacist recommendation. Subsequent to a fall on 1/16/14, Resident #174's care plan was updated on 1/16/15. The goals identified was resident will be kept comfortable and pain-free every shift within the next 7 days; resident will maintain level of care within the next 7 days; and resident will be free from injury related to fall in the next 30 days. The interventions remained the same as the 12/26/14 care plan with the addition of answer call light and alarm promptly and offer toileting every two hours while awake offer to assist resident to use the bathroom before going out for meals, activities and going back to bed. This care plan was crossed diagonally with handwritten note, resolved 1/23/15. Following a second fall on 2/2/15, the resident's care plan was updated on 2/2/15. The goals identified were the same as the care plan dated 1/16/15. The care plan included the same interventions in the discontinued care plan with the addition of the following interventions: bathroom door alarm always on; bed alarm in place and on; floor mattress in place; follow neuro check protocol; notify MD/NP and family; assess for possible injury, change in LOC; and monitor for signs and symptoms of delirium and infection and update MD/NP. After the fall of 2/2/15, Resident #174 complained of pain. Review of the IPN documents resident	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 19 complained of pain and swelling was noted to the right hand on the following dates: 2/2/15 at 1145 pain (head) and a headache; 2/2/15 at 2300 redness to back of right hand; 2/3/15 at 1020 complained of chest pain and pain to both upper arms; 2/3/15 at 1050 complained of pain which was relieved with morphine sulfate; 2/3/15 at 1300 the resident complained of pain to right wrist, 10/10, refusing medications; 2/5/15 at 0950 the resident right hand slightly swollen; 2/5/15 (late entry) complain of pain to right wrist; 2/6/15 at 0930 right hand red with order for x-ray; 2/6/15 at 1330 the resident confused for 2 days; 2/7/15 at 1110 complained of right wrist pain; and 2/7/15 at 1900 right hand still swollen. The physician documents on 2/2/15 the resident has a hematoma along the scale on the right side and bruising of the right wrist. The physician note of 2/9/15 documents resident has a radial fracture with the recommendation for use of splint. On 2/11/15 at 9:28 A.M. an interview was done with Resident #174. The resident was aware that she fell twice. Inquired what happened, she stated that she was calling for help and when she has to wait for 15 to 20 minutes she has to go to the toilet by herself. She reported her call light works. Inquired what happened to her wrist, she replied she has a fracture, she hurt herself when she tried to brace the fall and commented that she fell because she is "old". The resident reported the splint is "humbug" because she can't use her hand. The resident also shared that the first fall was her fault because she did not wait for staff to answer her call light and was rushing to go to the bathroom and was in the hallway looking for help. She also reported the second time she fell it was the same thing, she was rushing around to get to the bathroom. The resident added not to be too hard "on them, I	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 20 really blame myself, if I listen to them and waited". The resident commented that it is embarrassing to make "shi-shi" (urinate) in your pants. Interview and concurrent record review was done with the Director of Nursing (DON) on 2/12/15 at 8:27 A.M. The first fall (1/16/15) was reviewed with the DON. Review of the facility's report with the DON, highlighted that the report documents the resident has a bed alarm, did that sound before the resident was found on the floor in the first fall. The DON's response was that she thinks a bed alarm was applied in response to the actual fall and was not implemented before the fall. Inquired whether an alarm was heard as care plan indicates resident has a personal alarm on at all times. The DON responded that her assumption is that the resident took it off and that's why staff members did not hear the alarm. Further queried whether a thorough root cause analysis was done and the care plan was revised based on the analysis. The DON responded affirmatively. The DON replied a bed alarm was added as well as checking on the resident more frequently and offering toileting every two hours while awake. Inquired how often is "frequently"? The DON confirmed the care plan does not specify how often staff members are to check on the resident and the care plan was not updated to include the use of a bed alarm. The DON stated the resident was trying to get to the restroom. Inquired whether the facility's analysis included the availability of staff, call light response time, if bed alarm was in use at that time and an assessment of the resident's abilities for toileting was done. The DON was asked whether the facility did a root cause analysis and implemented appropriate interventions based on their analysis. The DON replied "probably not".	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 21 The resolved care plan dated 1/16/15 was reviewed with the DON. Inquired why this plan was resolved and the facility reverted back to the initial plan that was in place when the resident had her first fall and subsequently had another fall on 2/2/15. The DON surmised the plan dated 1/16/15 was for a seven day period and would need to reeducate the nurses on care plan. The second fall of 2/2/15 was reviewed with the DON. Queried DON regarding the alarm as the report documents an alarm was heard, asked which alarm sounded as the resident has a personal alarm, bed alarm and there is an alarm on the bathroom door. The DON replied probably the bathroom alarm. Inquired whether the use of medication (mirtazapine, prn lorazepam and prn morphine) contributed to the fall. The DON acknowledged a side effect of mirtazapine has side effect of dizziness, similar to side effects related to taking a sleeping pill. The DON confirmed the use of medication was not included in the analysis. On 2/11/15 at 9:16 A.M. observation was made with Certified Nurse Aide #6. The CNA confirmed the bed alarm was in place; however, there was a cord that was not plugged in. The CNA reported this was the cord for the call light and plugged in the cord. Observation on 2/11/15 at 1:58 P.M. found the resident lying in bed, no mats on the floor. The resident's front wheeled walker was closed and placed against the wall. At 2:42 P.M. Licensed Nurse #1 (LN #1) was asked if mats on the floor are used for Resident #174. The LN stated floor mats are used for this resident as she is at high risk for falls. The LN entered the resident's room and found the resident did not have floor mats. The LN proceeded to place a	4 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 130	Continued From page 22 mat on both sides of the resident's bed. At 3:02 P.M. the LN was asked how are the floor mats used for this resident as there is an observation of the resident having two floor mats stacked atop one another and placed to the resident's left side of the bed. The LN responded a mat should be placed on both sides of the resident's bed. Further queried what does the care plan specify for the placement of the floor pads. LN #1 confirmed the care plan was not specific on placement of mats. The facility did not ensure a thorough analysis of the resident's falls. Resident #174's care plan interventions were updated to prevent future falls. Following the fall on 1/16/15 the care plan was updated with an addition of two interventions to the original plan and resolved on 1/23/15, reverting to the previous care plan interventions which were in place when the resident had her first fall. The resident experienced another fall on 2/2/15, which resulted in actual harm, radial fracture requiring splints. 3) On 02/13/2015 at 9:35 AM An interview with the DON, Administrator (ADM) and Quality Assurance Auditor (QA) when asked about reporting of R#1's fall to the state surveyors office the DON stated, "I assumed the Administration would submit a report (to the State agency) and he thought I would do the report." There was no follow up with ADM or DON if the fall was reported to the State Agency. The report of the fall was never filed to the state agency at the time of the survey.	4 130		
4 131	11-94.1-29(b) Resident abuse, neglect, and misappropriation	4 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 131	Continued From page 23 (b) All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source or origin, and alleged misappropriation of resident property shall be reported immediately to the administrator of the facility, and to other officials in accordance with state law through established procedures. This Statute is not met as evidenced by: Based on record review, interview with staff members and review of the facility's policy and procedures, at the time of the survey, the facility failed to report alleged violations immediately to the State agency and ensure a thorough investigation was completed for 2 of the 3 residents investigated for falls and elopement in the Stage 2 census sample of 38. Findings include: 1) Resident #174 fell on 2/2/15 which resulted in a radial fracture. Interview was done with the Director of Nursing (DON) on 2/12/15 at 8:27 A.M. Inquired what events are reportable to the State Agency. The DON responded any incident that requires medical attention or intervention which requires splinting. Inquired when did the facility become aware Resident #174 sustained a fracture? The DON stated 2/9/15 and confirmed this is a reportable incident which requires an initial report within 24 hours to the State Agency and the final report to be completed in five days. The DON reported that the previous Administrator would do the reporting and there was miscommunication with the new Administrator. The DON confirmed an initial report was not sent to the State Agency. 2) The R #1 had a history of elopements on	4 131	**4 131- RESIDENT ABUSE, NEGLECT AND MISAPPROPRIATION** #1 – **Resident** Res#174 fall risks were analyzed and additional interventions (i.e., floor mats on both sides of beds, and a bowel and bladder monitoring) were implemented with the intention of reducing resident's risk of falls and/or injury due to a fall. The initial report for Res.#174, to State Agency (SA) was filed along with the final investigation report on 2/10/15, which was within 5 working days of determining an injury had occurred. Res #1's Elopement risks/hazards have been analyzed and interventions have been implemented to include a wander alert bracelet that will activate an alarm should this resident approach an elevator in an attempt to leave facility unattended. Res.#1 Fall risks and care plans have been reviewed by clinical staff, and determined to be adequate, as indicated by prevention of falls for 9 months to date.	2/13/15 2/10/15 2/20/15 2/20/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 131	Continued From page 24 9/7/13, 7/27/14, and 1/9/15. A review of the facility's "Occurrence Investigation Form " indicated that the facility failed to identify, analyze, and update interventions for the risks/hazards. For each elopement, the facility failed to report to the SA. The R #1 had a history of falls on 10/19/13, 3/31/14, 4/20/14 (resulting in left tibial fracture), and 6/9/14. A review of the facility's " Occurrence Investigation Form" indicated that the facility failed to identify, analyze, and update interventions for risks/hazards. For each fall, the facility failed to report to the SA. A review of the facility's policy titled, " Occurrence Event Report for Residents & Visitors", revised 4/15/08, indicated reportable events included: a. Witnessed and unwitnessed falls/slips; k. Elopements: The policy noted, " II. Documentation: e. Events alleged as possible abuse/neglect will be subject to further investigation and reporting, as appropriate, to the Department of Health, Office of Healthcare Assurance, by the Adminstrator within the required reportable time as regulated; f. Event reports will be analyzed and monitored for trending and further action/recommendations as presented during the quarterly Quality Improvement Committee meetings. The facility failed to evaluate injuries/elopements using root-cause analysis to prevent further accidents. The facility failed to report significant injuries/elopements to the State Agency (SA).	4 131	#2 – **Other Residents** Each resident having a fall or an elopement from facility property requires that a report and investigation be completed in order to: 1) Determine if any violations involving mistreatment, neglect or abuse are identified; 2) Determine root-cause of incident to identify possible interventions that may assist in reducing risks/hazards to the resident. #3 – **Systemic Changes** INVESTIGATION - A revised Quality Assurance(QA) Incident and Investigation report is being implemented and put in to use by facility after training is completed with licensed nursing staff. These reports will be completed by Licensed Nursing staff immediately upon any required incident, including falls and elopements from property of facility. Each incident will be discussed in an Interdisciplinary Team(IDT) meeting to ensure investigations are in progress as needed, completion thereof, and to analyze, identify and update any interventions that may reduce risks and hazards to residents. A trending report will be updated on these same days, and the report will be reviewed weekly by the IDT. This data will then be compiled and reported to the Quality Assurance Performance Improvement (QAPI) Committee on a quarterly	
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient	4 148		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 148	Continued From page 25 in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by:	4 148	basis for further review and recommendations. REPORTING - Administrator recognizes and accepts sole responsibility of ensuring any and all reportable incidents will be reported to State Agency within required times. DON will carry out reporting requirements in absence of Administrator **#4 - Monitor**	
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty-first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided.	4 149	To ensure Quality Assurance is maintained, the facility's Incident Log (Trending Report) will be randomly audited by the Quality Assurance Auditor on a monthly basis to ensure compliance of investigations as well as reporting requirements to SA	3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 26 This Statute is not met as evidenced by: Based on observation, resident and staff interviews, and medical record review, the facility failed to revise the care plans and use the results of assessments to develop a care plan to include measurable objectives to meet a resident's medical and nursing needs to maintain their highest practicable physical and psychosocial well-being for 3 residents (R #1, R #174, and R #162) of the 15 care plans reviewed in the Stage 2 sample of 38 residents. Findings include: 1) A review of the care plans for R #1 on the afternoon of 2/11/15 found the interventions for Elopement were not being implemented. The R #1 had a history of elopement in which he would leave the facility premises and go to a neighboring store. The R #1 continued to elope after the care plan was implemented on 7/27/14. The care plan indicated the R #1 had a Wanderguard alarm in place. Observations on the afternoon of 2/12/15 found the R #1 did not have a Wanderguard alarm on his wheelchair as was indicated on the care plan. The R # 1 eloped after the 7/27/14 care plan was created on 1/9/15. A review of the care plans for R #1, on the afternoon of 2/11/15 found the interventions for Falls were not being implemented. The R #1 continued to have falls after the update of the Falls care plan on 3/15/14. The interventions remained the same and had not been updated despite additional falls on 4/20/14 and 6/9/14. One of the interventions in place since 3/15/14 was, "Use the mechanical lift with 2 persons assisting him for transfers. "The intervention was contrary to the RAI dated 6/8/14 (after the 4/20/14	4 149	**4 149 - NURSING SERVICES** **#1 – Resident** A 1:1 supervision care plan was developed for Res #1 with elopement concerns, on 2/13/2015. On 2/20/15, the facility procured and tested a functioning wander guard band and attached to R#1's wheelchair. R#1's 1:1 supervision was discontinued on 2/23/15, and the care plan was adjusted accordingly. A revised Elopement Care Plan for R#1 was created on 2/23/2015 to include the wander guard and the intervention to initiate a 1:1 sitter, in the event that a wander guard band is not available. R#1's ADL sheets, care plan and care card were reviewed on 2/11/15 by Charge Nurse. It was confirmed that these documents indicated a 2 person transfer with mechanical lift. FS re-educated all 4th floor unit staff on the importance of reviewing care plans and ADL sheets on a daily basis. FS counseled the involved MDS nurse on using documentation available in the record to ensure accurate coding. FS re-educated all LN on the 4th floor, on the importance of updating care plans with new interventions, every time a change to the plan of care has been made, or in the event that a hazardous event has occurred and the importance of ensuring that all interventions listed on	2/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 27 fall with fracture) which indicated the R #1 was to be transferred with 1 person assistance. The R #1 fell again on 6/9/14. The R #1 is a large man with a big frame and a diagnosis of paraplegia. Interview of the DON on the afternoon of 2/12/15 revealed her understanding that the R #1 was to have a Wanderguard alarm on his wheelchair. She reported that the facility did not have enough Wanderguard alarms for all the residents who needed them. The facility's approach was to assess who needed the Wanderguard most based on their cognizance. Interview of Certified Nurses Aide, CNA # 1 on the morning of 2/12/15 revealed R #1, "No longer used the Wanderguard alarm." She stated the resident previously used the Wanderguard alarm but no longer had one. Interview of Licensed Nurse, LN # 2 on the morning of 2/12/15 revealed R #1 no longer used the Wanderguard alarm. On the morning of 2/12/15, the Environmental Services Coordinator (ESC) was looking for a resident on the 4th floor (where R #1 resided) to test the Wanderguard alarm system. The staff on the 4th floor informed the ESC that no one on the 4th floor used a Wanderguard alarm. Interview of the CNA # 1 on the morning of 2/12/15 revealed the R #1 had always required 2-person assistance for transfers. Interview of LN # on the morning of 2/12/15 revealed the R #1 had always required 2-person assistance for transfers. The fall that occurred on 4/20/14 was the result of the CNA trying to transfer the R #1 without another person. 2) Resident #174 is prescribed lasix, mirtazapine and prn lorazepam. The care plan was not	4 149	the care plan are active and being performed. FS#1 re-educated all C.N.A's of the importance of checking the care card and the ADL sheets, on a daily basis to ensure that assistive devices are in place, as well as ensuring that the plan of care is followed Charge Nurse completed an impaired vision care plan on 2/11/15, for R# 162, to include safety interventions specified for vision impairment concerns. FS counseled the involved MDS nurse that completed the assessment for Res # 162, on ensuring that the care plans are created/ updated based on the MDS assessment as well as using documentation available in the patient records to ensure accurate coding. Charge nurse created a care plan for R#174 on 2/12/15, to include current psychoactive medications, as well as behaviors to watch for and side effects of the medication (Mirtazapine and Lorazepam). Monitoring sheets were revised (2/12/15), to include the side effects of the medications lorazepam and mirtazapine, and to include non-pharmacological interventions and parameters before the use of the prn medications. FS #1 counseled all 4th floor staff on	2/23/15 2/11/15 2/11/15 2/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 28 specific to include the side effects for the use of mirtazapine, lasix and lorazepam. Interview with the licensed nurse (LN) confirmed that staff members are not aware of side effects to monitor for the use of these medications. The LN was unable to identify side effects related to the use of mirtazapine and lasix. The care plan did not include non-pharmacological interventions and parameters for the use of prn medication, lorazepam. 3) Resident #162 was selected for Stage 2 sample for vision review. Record review was done on 2/11/15 at 7:51 A.M. A review of the comprehensive Minimum Data Set (MDS) with assessment reference date of 11/11/14 notes Resident #162 has impaired vision (sees large print, but not regular print in newspapers/books) and does not have corrective lenses (contacts, glasses or magnifying glass). Review of the Care Area Assessment notes visual impairment was triggered due to having impaired vision and is at risk for further decline in visual function due to diagnosis of cataract. The plan was to continue care plan with goals for resident not to have signs and symptoms of eye infection and to read large print without glasses for the next 90 days. The decision was to care plan. Review of the resident's care plan found there is no care plan to address the resident's impaired vision. Interview with Floor Supervisor #1 (FS #1) was done on 2/11/15 at 8:00 A.M. The FS reported the resident has glasses and found glasses was found on the inventory list. Concurrent review of the care plan was done. The FS confirmed the resident does not have a care plan with goals and interventions to address his visual impairment. 4) On 02/13/2015 9:51 AM at a meeting with the	4 149	2/23/15, on the importance of non-pharmacological interventions, current psychoactive medications, as well as behaviors to watch for and side effects of the medication (Mirtazapine and Lorazepam). In addtition to the importance of knowing the reason for administering a prescribed medication, as well as possible side effects associated with this medication **#2 – Other Residents** Current and future residents manifesting wandering behavior will be considered to be at risk for wandering/elopement and have appropriate care plans initiated. Residents that have an incident report completed or an incident investigated will have specific interventions put into place as well as immediate update to related care plans. All residents who are on psychotropic medications will be assessed and care plan updated. Residents name listed in the psychotropic med list sent by the pharmacy to DON/Supervisor for audits of care plans and complete documentation on all required forms. Audit of current residents who have been triggered by the MDS as having vision impairment will be assessed for	2/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 149	Continued From page 29 DON, Administrator, Quality Assurance Auditor (QA) to discuss the quality assessement and assurance activities of the facility. The Administrator and QA verified that the Quality Assessment and Assurance committee does not look at resident specific concerns. The DON and QA stated care plan issues may be a quality assurance project. 5) Resident #174 was identified to be at high risk for falls upon admission. A care plan was developed on 12/26/14. The resident had a fall on 1/16/15 with a care plan update to include two additional interventions to the original care plan. The revision was not based on a thorough causal analysis. This care plan was "resolved" on 1/23/15 and the 12/26/14 care plan was not revised, reverting to the original care plan that was being implemented when the resident had her first fall. Subsequently, the resident had another fall resulting in a radial fracture to the right wrist.	4 149	complete and patient specific care plans and interventions. Monthly resident summaries will assess for changes in visual abilities. **#3 – Systemic Changes** All incident reports will be discussed daily in IDT meetings and during care conferences. In-service IDT involved in care planning on proper documentation and revision of care plans. New incident report form to include resident participation to determine new interventions will be developed and implemented on 03/30/2015 after staff education is completed. This form will include a step by step guide to investigate an event for a root-cause. The new incident report and incident investigation will be maintained in a binder that will be specific to events only. This binder will provide information on every step that will need to be completed for that specific event (i.e. Contact family, update the care plan, update the behavioral monitoring sheet, investigate the resident etc.) **#4 – Monitor** Care plans are reviewed with scheduled	3/30/15 and Ongoing 3/30/15 and Ongoing 3/30/15 and Ongoing
4 152	11-94.1-39(e) Nursing services (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician	4 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 152	Continued From page 30 and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Statute is not met as evidenced by: Based on medical record review and interview with staff members, the facility failed to ensure 1 (Resident #174) of 5 residents selected for unnecessary medication review received adequate monitoring for side effects and indications for use. Findings include: Resident #174 was admitted to the facility on 12/26/14 with hospice services. The physician's orders include: mirtazapine 15 mg. (one tab by mouth at bedtime for situational depression); lasix 20 mg. (take one tab by mouth once daily as needed for edema) and lorazepam 1 mg (one tab every 4 hours as needed for anxiety/agitation). Review of the Medication Administration Record (MAR) notes an attempt was made to administer lorazepam on 2/6/15 at 0255 for severe agitation, the resident spit the medication out. A sticky note was found attached to a page of the MAR dated 2/3/15 documenting the resident's daughter informed the facility that lorazepam causes confusion for the resident, "try not to give it".	4 152	MDS assessments. All staff will be in-serviced regarding the use of the new incident report form, and reported in QAPI meetings. Nursing Supervisors will be reviewing the event report forms upon receipt and submitted to the DON/Administrator. Each incident will be discussed in IDT meeting to ensure investigations are in progress as needed, completion thereof, and to analyze, identify and update any interventions that may reduce risks and hazards to residents. A trending report will be updated on these same days, and the report will be reviewed weekly by the IDT. This data will then be compiled and reported to the QAPI Committee further review and recommendations.	3/30/15 and Ongoing 3/30/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 152	Continued From page 31 Review of the admission Minimum Data Set (MDS) with assessment reference date of 12/30/14 notes Resident #174 yielded a 14 (cognitively intact) when the Brief Interview for Mental Status was administered. Review of Section D (Mood) and Section E. (Behavior),the resident was not coded for mood and behavioral symptoms. Review of the Care Area Assessment for psychotropic medication notes Resident #174 is prescribed mirtazapine for diagnosis of situational depression which is exhibited by refusal of care and sad facial expression. These behaviors were not observed and the resident did not have side effects related to the use of mirtazapine. The decision was to care plan with goal that resident's behavior will be controlled and will not have any side effects related to medication. Review found a care plan dated 12/30/14 for remeron (mirtazapine). Interventions include offer emotional support/counseling when she wants to talk openly; assess resident's emotional status (use geriatric depression scale); collaborate with [name of hospice facility] nurse and social worker; find out from resident or family what [name] enjoys doing and who she likes to socially interact with; and allow resident to express her spirituality. The resident has a care plan (dated 1/9/15) for diagnosis of dementia and lorazepam prn if she gets agitated. The interventions include observe for signs of delirium - change in cognition, mood, behavior, and overall personality and report to LN, PCP; anticipate resident's needs and provide her with cues and reminders if needed; and give her clear cues, one at a time, and do not over stimulate. The care plan was not specific to include the side effects for the use of mirtazapine (remeron),	4 152	**4 152 – NURSING SERVICES** **#1 – Resident** Charge nurse created a care plan for R#174 on 2/12/15, to include current psychotropic medications, as well as behaviors to watch for and side effects of the medication (Mirtazapine and Lorazepam). FS#1 updated the behavior monitoring sheets was revised (2/12/15), to include the side effects of the medications lorazepam and mirtazapine, and to include non-pharmacological interventions and parameters before the use of the prn medications. FS #1 counseled all 4th floor staff on 2/23/15, on the importance of non- pharmacological interventions, current psychoactive medications, as well as behaviors to watch for and side effects of the medication (Mirtazapine and Lorazepam). FS #1 counseled all 4th floor staff on 2/23/15 on the importance of knowing the reason for administering a prescribed medication, as well as possible side effects associated with this medication. **#2 – Other Residents** All residents who are ordered psychotropic medications will be assessed for behaviors that require the administration of psychotropic medications. Collaboration is done	2/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 152	Continued From page 32 lorazepam and lasix. The care plan did not include indications for use (when to administer prn lorazepam). An interview was conducted with Licensed Nurse #2 (LN#2) on 2/11/2015 at 8:57 AM. Queried LN #2 regarding the side effects related to the use of mirtazapine. The LN #2 paused and stated increased weight. Inquired what are side effects related to the use of lasix (furosemide). The LN #2 paused and said the use of lasix decreases sodium. Concurrently reviewed the Behavior/Intervention Monthly Flow Record for use of mirtazapine, the listing for side effects was blank; however, nursing staff are documenting "0" for observations of side effects that were observed during their shift. The Social Worker (SW #1) was interviewed on 2/11/15 at 2:00 P.M. The SW #1 reported that the resident was admitted to the facility with mirtazapine. On admission the resident was placed in a private room (the designated isolation room) as this was the only space available. Resident #174 was moved to a room with other residents (4 bed room). Inquired why the lorazepam prn was prescribed for this resident. The SW #1 replied the resident is diagnosed with dementia and receives hospice services and residents on hospice occasionally become restless and agitated; therefore, lorazepam is prescribed. The SW #1 also reported that Resident #174 oftentimes expresses paranoid thoughts about people talking about her. The SW #1 reported the nurses will administer lorazepam when the resident is calling out as the resident needs "a lot of attention and reassurance" and when she is resistive to care. The SW #1 confirmed that the care plan does not include non-pharmacological interventions and	4 152	with the hospice agency to determine specific parameters when the psychotropic medication is initiated by hospice **#3 – Systemic Changes** "Behavior" care plan will be made available to all units immediately by 3/16/15 and will be updated to include a section to document prescribed medications for behaviors, and an area in which to list side effects associated with that medication. The policy and procedure for medication administration will reviewed and revised. Education will be performed to all licensed nurses to ensure the understanding of the revised P&P, as well as nursing practice expectations. Re-education will be completed for all staff regarding the specifics of the current fall protocol. **#4 – Monitor** The CN will do a monthly review of behavior monitoring sheets; to determine effectiveness of interventions The charge nurses will	3/30/15 and Ongoing 3/27/15 3/30/15 3/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 152	Continued From page 33 parameters are not clear to identify when to administer lorazepam. Review of the Behavior/Intervention Monthly Flow Record was done with the SW #1. The flow record for January 2015 list the following behaviors to monitor related to the use of mirtazapine for situational depression, refuse care, sad facial expression and agitation. The February 2015 flow record notes the staff are monitoring for agitation for prn medication with diagnosis of situational depression and use of mirtazapine. The SW #1 confirmed the February flow record to monitor agitation should be related to lorazepam, not mirtazapine. Interview was done with Licensed Nurse #2 (LN #2) on 2/11/15 at 2:29 P.M. Inquired when would she administer a prn of lorazepam. The LN #2 reported she has not observed the resident to be agitated so could not identify the parameters for administering a prn of lorazepam. Interview was done with the Director of Nursing (DON) on 2/12/15 at 9:50 A.M. The flow record was reviewed with the DON. The DON confirmed lorazepam is prescribed for agitation, not the mirtazapine. Resident #174 has been prescribed routine lasix and mirtazapine with prn order for lorazepam. The facility failed to ensure the resident is being monitored for side effects related to the medication as the side effects were not identified in the care plan or Behavior/Intervention Monthly Flow Record. The facility did not develop non-pharmacological interventions to address Resident #174's specific needs related to diagnosis of situational depression. Also, the facility is not monitoring the behavior of agitation	4 152	annotate the completion of this audit, in the comment section on the behavior monitoring sheets. Charge nurses will also document the audit in the IDT notes as well as document the need for care plan changes, in the resident's chart. Care Plan updates are reviewed at the care conference DON will use the monthly list of residents on Psychotropic medications in the facility, provided by the pharmacy, to audit monthly for proper documentation as well as for the appropriate use of non-pharm interventions.	3/30/15 and Ongoing 3/30/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 152	Continued From page 34 identified for the use of mirtazapine. The facility did not ensure specific indications for use of prn lorazepam was identified.	4 152		
4 195	11-94.1-46(l) Pharmaceutical services (l) All drugs, including drugs that are stored in a refrigerator, shall be kept under lock and key, except when authorized personnel are in attendance. The facility shall be in compliance with all security requirements of federal and state laws as they relate to storerooms and pharmacies. This Statute is not met as evidenced by: Based on observations, staff interviews, and facility policy review, the facility failed to properly store/lock and discard expired medications. Findings include: 1) During medication pass on the morning of 2/10/15 at 8:30 A.M., Licensed Nurse #2 left 2 inhalers for R #115 in the resident's bathroom. She returned to her medication cart and began passing medications for the next resident. She didn't return to the bathroom to retrieve the Advair and Spiriva inhalers until the Surveyor brought it to her attention. She stated that she was supposed to bring the inhalers back to the medication cart to store them. 2) During the initial tour on the morning of 2/9/15, a treatment cart on the 4th floor was left unattended and unlocked. An interview with Licensed Nurse #1(LN#1) revealed that the Certifed Nurses Aide (CNA) must have left it unlocked to run and get something. LN # 1	4 195	**4 195 PHARMACEUTICAL SERVICES** **#1 – Resident** Hazardous items in the broken treatment cart were secured in a locked cart on 2/9/15. Involved staff members were counseled by the FS, on the importance of securing prescribed meds, not to leave any medication unattended on 2/13/15. The treatment cart was replaced with a functioning cart on 2/17/15. Prescribed medication will only be accessible to LN staff. Nurses on the units where expired medications were found, were counseled on the importance of checking all medications for expiration on the assigned day by FS on 2/13/15. Expired medications were discarded. **#2 – Other Residents** All residents with prescribed medications are at risk. **#3 – Systemic Changes**	2/17/15 3/17/15 2/13/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 195	Continued From page 35 stated it should be locked at all times. The treatment cart was stocked with items such as topical medications, scissors, and scissors. The CNA did not return after approximately 5 minutes. The treatment cart was sitting at the end of a hallway where residents and visitors passed through. On the morning of 2/11/15, a review of the facility's policy titled, "Medication Storage in the Facility", noted 2. Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 3) On 2/11/15 at 10:45 A.M. one of the treatment carts on the fourth floor was left unlocked between resident rooms 405 and 406. There were medication creams and ointments in the first drawer. An interview was conducted with Certified Nurses Aide #3 and she acknowledged that the treatment cart should be locked at all times. An interview was conducted with the Floor Supervisor #3 on 2/12/15 at 09:56 A.M. She stated that the treatment carts should be locked because they contain medications such as treatment creams and ointments. On the morning of 2/12/15, a review of the facility's policy titled, "Medication Storage in the Facility", noted Procedure 2: Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and	4 195	Medications provided by outside pharmacies will be reviewed for appropriate labeling, absence of tampering, and the expiration date of the Resident medications, upon arrival to the facility. All licensed staff will be have in-service on importance of securing all medications and on the expectation to perform a thorough weekly medication audit to include low stock and expiration dates **#4 – Monitor** LN will audit 100% of meds for expiration dates on a weekly basis for 4 weeks, then randomly on a quarterly basis. Pharmacy personnel will continue to visit the facility on a quarterly basis, to check medication supplies for proper labeling, storing and expiration dates. Pharmacy personnel will continue visit the facility monthly to observe licensed staff completing med pass. The findings of these visits will be reported in QAPI meetings. Nursing Managers will perform random observations during daily rounds to ensure compliance with properly securing medications for 3 months and then randomly thereafter.	3/30/15 and Ongoing 3/30/15 3/30/15 and ongoing 3/30/15 and Ongoing 3/23/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 195	Continued From page 36 medication supplies are locked or attended by persons with authorized access. 4) On 02/11/2015 at 2:27 PM on the second floor an observation of medications stored in the narcotic drawer located in the medication cart indicated that Morphine Sulfate, 30 ml bottle had expired on 1/31/15. An interview was conducted with Licensed Nurse #3 (LN#3) regarding the expired Morphine Sulfate medication. LN # 3 indicated that the expired Morphine Sulfate should have been discarded as medication checks are done weekly (usually Friday or Saturday). 5) On 02/11/2015 at 2:47 PM on the third floor, an observation of medications stored in the refrigerator located in the medication room indicated that 24 Bisacodyl 10 mg suppositories expired on 7/2014 and the Kaiser pharmacy label indicated an expiration date of 4/23/15. An interview was conducted with Licensed Nurse #4 and she indicated that medications are checked for expiration dates weekly. On the morning of 2/12/15, a review of the facility's policy titled, "Medication Storage in the Facility", noted Procedure 12: Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from the stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists.	4 195		

Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	Continued From page 37	4 203	**4 203 INFECTION CONTROL**	
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute is not met as evidenced by: Based on staff interview and observation the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment that will ensure reusable equipment is appropriately cleaned, disinfected, or reprocesssed. Findings include 1) On 02/10/2015 at 3:00PM the Environmental Services Coordinator (ESC) stated that shared facility equipment for residents are cleansed with Morning Mist. When asked about the contact time for cleaning the ESC stated 30 seconds. The Morning Mist printed product information states "Effective 10-minute contact time". The ESC read the Morning Mist product information literature which stated contact time of 10 minutes and stated "10 minutes is too long". On 2/11/2015 at 7:00AM Environmental Serivces #1 (ES #1) stated Morning Mist is used at the facility and contact time is 2 - 3 minutes. On 02/11/2015 10:27AM the Activity Assistant (AA #1) was observed wiping down a table in the actvity/dining room used by residents using an unlabled spray bottle with black handwritten wordings. AA#1 said the spray bottle was given to	4 203	**#1 – Resident** The table top where Res#69 had been seated was sanitized immediately after the concern was identified on 2/9/15. Resident involved was monitored for any signs and symptoms of conjunctivitis or possible cross-contamination. As of 2/23/15, there was no noted evidence of infection in the involved residents. Involved staff that were not aware of contact time for cleaning solution were counseled and re-educated on how to use current disinfectants on 2/13/15. Immediate research was performed for the replacement of Morning Mist with another form of disinfectant with a less contact time Involved staff that were not properly using PPE, were counseled and re-educated on 2/11/15. **#2 – Other Residents** All current and new residents will be assessed for infections and placed on the appropriate precautions.	2/23/15 2/10/15 2/11/15 2/13/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	Continued From page 38 him from housekeeping, he thinks is it Morning Mist, contact time is 1 - 5 seconds. AA#1 said he had no training on disinfection of the activity/dining tables. 02/11/2015 at 10:34 AM Certified Nurses Aide #2 (CNA #2) was interviewed near the shared resident bath/shower room. CNA #2 said she wipes down the shared resident bath equipment with the Morning Mist or sometimes the purple top sani wipes. When asked about contact time CNA #2 said the equipment is left to dry. CNA#2 said the Morning Mist is here (in the shower room) then she walked down the hallway to the nurses station; pointed out a purple top sani wipe cannister and stated sometimes she uses this one (to clean the shared bath equipment). On 02/11/2015 at 3:07 PM the Administrator (ADM), Director of Nursing (DON), and Infection Control Coordinator (LCC) who was present by phone conference met to discuss infection control policies. The LCC was informed that Morning Mist is used at the facility, when random staff were queried about contact time for use of faciltiy sanitizers there were many different responses. Staff also were using different sanitizers for shared equipment; and the ESC was not following the recommended Morning Mist policy on contact time. The LCC stated, "no, they do not use Morning Mist, the facility uses the Purple top sani wipes". The ADM and DON informed the LCC that the facility does use Morning Mist. The ADM stated the faciltiy uses Morning Mist, Purple top sani wipes and Orange top sani wipes. The LCC stated "this is a weak point in the program (Infection Control) I am disappointed." 2) On 2/9/15 at 9:32 A.M. observed Resident #69 (R #69) seated in the dining/activity room with his	4 203	**#3 – Systemic Changes** All staff will be retrained on the use of new disinfectant and other cleaning products and procedures. Re-educate, with involvement of facility's Infection Control Consultant, all staff on the proper use of PPEs, the prevention of cross-contamination, disinfection processes, understanding of infection control precautions, as well as available disinfectants and the "stay" time required for each, for appropriate decontamination. This education will be provided to all new employees during orientation, and during the annual competency reviews. In-service all staff on the need to disinfect all shared surfaces utilized by res. on contact isolation precautions. LN will assess daily, residents that are on infection control precautions. Those residents that cannot leave their room due to spread of infection concerns will be identified. This list will be provided to C.N.A.'s by way of assignment sheets. This information will be endorsed from C.N.A. to C.N.A. at change of shift, and will be documented on the C.N.A endorsement log.	3/19/15 and Ongoing 3/30/15 and Ongoing 3/30/15 and Ongoing 3/30/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	Continued From page 39 hands on the table. He was seated between two residents. Licensed Nurse #2 (LN#2) was observed to wheel the resident out of the room. The LN #2 stated R #69 was being taken back to the room to wipe his eye as he as he has drainage from his eye. Another staff member wheeled Resident #76 (R #76) into the room and placed R#76 at the table where R #69 was seated. The table was not sanitized after R #69 was removed. There is signage at the entrance to the resident's room to notify visitors of "Contact Isolation". Second observation at 9:38 A.M. found R #69 seated at a table by himself. Third observation on 2/22/15 at 8:14 A.M. found R #69 seated at a table with three other male residents in the front of the room. Record review done on 2/11/15 at 8:15 A.M. noted R #69 has a physician's order for polytrim ophthalmic drops for conjunctivitis QID for seven days. The resident's care plan noted polytrim ophthalmic drop to both eyes for seven days for conjunctivitis. Interview with Floor Supervisor #1 (FS #1) was done on 2/11/15 at 8:22 A.M. The FS reported after two days of being on antibiotic the resident can go out into the population; however, is kept away from other residents. The observation done on 2/9/15 was shared with the FS #1 and inquired whether the table area should be sanitized before placing another resident in his spot. The FS replied that the wipe cloths with the purple top should be used to wipe the area before placing another resident at the table. 3) On the morning of 2/9/15 observed signage at the entrance of Room 404 for "Contact Isolation". Interview with Floor Supervisor #1 (FS #1) was done on the afternoon of 2/11/15. The FS reported Resident #92 (R #92) has ESBL (extended spectrum bacta-lactamase). On	4 203	**#4 – Monitor** Nursing Managers and staff educator will develop an audit tool to monitor staff compliance and conduct random observations on adherence to proper isolation precautions including disinfection procedures and the use of PPEs daily for 30 days, and then randomly thereafter.	3/30/15 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	Continued From page 40 2/11/15 at 2:46 P.M. observed Licensed Nurse #1 (LN #1) placing pads on the floor next to Resident #174's bed. Observed a Certified Nurse Aide (CNA) donned in a gown, glove and mask emerge from behind R #92's closed curtains to assist LN #1. The CNA did not remove her personal protective equipment (PPE) and was observed to touch the fall pads to assist the LN. The CNA then went back to R #92's bedside without changing PPE to provide care to R #92. Upon query the LN #1 confirmed an infection control breach occurred when the CNA assisted her without removing personal protective equipment. The LN #1 stated that she will sanitize the floor pads. 4) During multiple observations in the morning and afternoon of 2/9/15, staff made several breaks in infection control. At approximately 9:50 A.M., a resident room (Rm. 405) noted one or more resident(s) in the room was on droplet precautions. The sign indicated that persons entering the room required the Personal Protective Equipment (PPEs): goggles, gown, and gloves (if touching resident). A staff member was observed exiting the room without any PPEs. An interview with the Licensed Nurse #1 (LN #1) revealed that staff should be using PPEs to include goggles, gloves, and gown. A Certified Nurses Aide #4 (CNA #4) was observed on the afternoon of 2/9/15 exiting a resident room (Rm. 413) with droplet and contact precautions without any PPEs after bringing his lunch tray into his room. The Certified Nurses Aide (CNA) then put a facial mask on before reentering his room. An interview of the CNA #4 revealed an understanding that she should've had a mask on before entering the room the first time.	4 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	125043	A. BUILDING: _____ B. WING _____	02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL CITY NURSING HOME	919 LEHUA AVENUE PEARL CITY, HI 96782

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	Continued From page 41 In the afternoon of 2/9/15, a Licensed Physical Therapy Aide, LPTA, was observed exiting the same room where the resident was on droplet/contact precautions. Another Certified Nurses Aide #5 (CNA #5) was observed leaving the same droplet/contact precaution room without a mask, gown, and gloves. She emptied the resident's trash in the hallway. When she returned to the room, she then put on a mask, gloves, and gown. The CNA #5 validated that she should've had PPEs on when she went in to get the trash.	4 203		